EXTENDED SERVICES EMPLOYMENT PLAN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
SFN 1593 (1-2012)

Clear Fields

Print using black or blue ink pen (no pencil). Incomplete or indecipherable forms will not be accepted.

Consumer's Name		Date	☐ Initial Plan ☐ Annual Review
Address			Apartment Number
City	State	ZIP Code	E-Mail Address
Telephone Number (Home)	Telephone Number (Work)		Telephone Number (Cell)
Employment Goal			
Employer			
☐ Competitive Employment ☐ Self Employment ☐ Crew Placement			
If Crew Placement, detail the justification for such a placement			
Hourly Wage	Hours Worked Per Month		Hourly Wage
Community Rehab Provider			
Address			Suite Number
City	State	ZIP Code	E-Mail Address
CRP Contact Person			Telephone Number
To maintain my job, I need the following:			
Barriers to independent employment:			
My responsibilities in maintaining my work goal are:			

By signing this document, I understand and commit to the responsibilities in my Employment Plan

Consumer	Date
CRP Rep	Date
VR Counselor	Date
Case Manager (Mental Health)	Date
Extended Services Coordinator	Date